

may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I
0
1
130

4985

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04973

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Levin</u> Middle <u>Bayne</u> Last <u>Bayne</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1880</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Noah Bayne</u>				14. MOTHER'S MAIDEN NAME <u>Maria ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-10-8401</u>		17. INFORMANT <u>Emma Bayne - Pocomoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with R. Hemiplegia</u> 443X DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Atherosclerosis, generalized, severe</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Several years</u> <u>Many years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24 Oct 1954</u> to <u>28 Sept 1961</u> , that (I) (we) last saw the deceased alive on <u>28 April 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>N.E. Sartorius, Jr.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>N.E. Sartorius, Jr., M.D.</u>	
22d. ADDRESS <u>114 Market St., Pocomoke City, Maryland</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke Holiness</u>		23d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

(1)

STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN THE MATTER OF

THE ESTATE OF

JOHN W. BROWN

DECEASED

VS.

JOHN W. BROWN

ADMINISTRATOR

OF THE ESTATE OF

JOHN W. BROWN

DECEASED

VS.

JOHN W. BROWN

ADMINISTRATOR

OF THE ESTATE OF

JOHN W. BROWN

DECEASED

VS.

JOHN W. BROWN

ADMINISTRATOR

OF THE ESTATE OF

JOHN W. BROWN

DECEASED

VS.

JOHN W. BROWN

JOHN W. BROWN, DECEASED, BY HIS ADMINISTRATOR, JOHN W. BROWN, VS. JOHN W. BROWN, ADMINISTRATOR OF THE ESTATE OF JOHN W. BROWN, DECEASED.

JOHN W. BROWN, DECEASED, BY HIS ADMINISTRATOR, JOHN W. BROWN, VS. JOHN W. BROWN, ADMINISTRATOR OF THE ESTATE OF JOHN W. BROWN, DECEASED.

JOHN W. BROWN, DECEASED, BY HIS ADMINISTRATOR, JOHN W. BROWN, VS. JOHN W. BROWN, ADMINISTRATOR OF THE ESTATE OF JOHN W. BROWN, DECEASED.

JOHN W. BROWN, DECEASED, BY HIS ADMINISTRATOR, JOHN W. BROWN, VS. JOHN W. BROWN, ADMINISTRATOR OF THE ESTATE OF JOHN W. BROWN, DECEASED.

JOHN W. BROWN, DECEASED, BY HIS ADMINISTRATOR, JOHN W. BROWN, VS. JOHN W. BROWN, ADMINISTRATOR OF THE ESTATE OF JOHN W. BROWN, DECEASED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04974

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle MAE Last BLADES				4. DATE OF DEATH Month April Day 21 Year 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1910	
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months 3 Days 7 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John William Taylor				14. MOTHER'S MAIDEN NAME Lula Dunston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address R.F.D. 3 Howard F. Blades, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1959 , to 4-21 , 1961 , that I last saw the deceased alive on 4-19 , 1961 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4-21-61							
ACTUAL SIGNATURE C. E. Critcher M.D.							
PHYSICIAN'S NAME (Type) C. E. CRITCHER				New Church, Virginia			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-61		22c. NAME OF CEMETERY Goodwill Methodist		22d. LOCATION (City, town, or county) (State) Rural-Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John William Smith		April 15, 1910	
Age		Sex	
45 years		Male	
Married		Occupation	
Yes		Carpenter	
Cause of Death		Place of Death	
Heart Disease		Home	
Direct Cause		Indirect Cause	
Myocardial Infarction		None	
Duration of Illness		Time of Day	
3 days		10:00 AM	
Physician		Burial Place	
Dr. J. H. Smith		St. John's Cemetery	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Issue	
April 16, 1910		Baltimore, Md.	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4987

04975

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 BROAD ST</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>1 BROAD ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>PURNELL</u> Last <u>BOSTON</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 13, 1893</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM R. PURNELL</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MAC GREGOR</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. J. SELBY PURNELL</u>				Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nonpigmented melanotic sarcoma</u> <u>190.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6 2205</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> 19 <u>60</u> to <u>April 7</u> 19 <u>61</u> that (I) (we) lost the deceased alive on <u>7 April 1961</u> , and that death occurred of <u>7:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>R. J. Thomas</u>				22d. ADDRESS <u>Ocean City, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE, THEREOF <u>4/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rene R. Burbage</u>				ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR DATE <u>APR 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

(I)

MEDICAL CERTIFICATION

bp

CERTIFICATE OF DEATH

1987

(M)

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Name of informant: _____

14. Address of informant: _____

15. Date of completion: _____

OFFICE OF THE SECRETARY OF HEALTH
WASHINGTON, D. C.

CHILD LIVING PRO

3882

CERTIFICATE OF DEATH

1934

[Faint, mostly illegible handwritten text, likely a signature or address.]

[Faint, mostly illegible handwritten text, likely a signature or address.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04977

4989

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke (Rural) all life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>1 Route 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Corbin</u> Last <u>Corbin</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 19, 1902</u>	
9. AGE (in years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>18</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Corbin</u>				14. MOTHER'S MAIDEN NAME <u>Addie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>631-16-1111</u>		17. INFORMANT <u>Bernie Schofield</u> Address <u>631 1/2 Main St. Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0 Conflagration</u> DUE TO (b) <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>916.0</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>916.0</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Worcester</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. SARTORIUS Sr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Chapel</u>		22d. LOCATION (City, town, or county) <u>Pocomoke, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>Pocomoke, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH 1902		PLACE OF DEATH Home	
DECEASED John C. Brown		RESIDENCE 123 Main St. Bellingham, Mass.	
AGE 42		SEX Male	
DATE OF BIRTH 1860		OCCUPATION Farmer	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE OF EXAMINATION 1902	
LOCALITY Bellingham, Mass.		COUNTY Bellingham	
STATE Massachusetts		FEDERAL DISTRICT Bellingham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4990

CERTIFICATE OF DEATH

Reg. Dist. No.

04978

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt # 3		d. STREET ADDRESS 1 Rt # 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Horace Middle Ellis Last Ellis		4. DATE OF DEATH Month 4 Day 19 Year 1961	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10 1899
9. AGE (In years, lost birthday) 61 yrs		IF UNDER 1 YEAR: Months 6 Days 14 Hours 45 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ellis		14. MOTHER'S MAIDEN NAME Annie Ellis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Elizabeth Baker, Salisbury Md		Address Salisbury Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Chronic Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 15 min 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/17 , 1961 , to 4/10 , 1961 , that I last saw the deceased alive on 4/10 , 1961 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin, Md DATE SIGNED 4/21/61	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD		Berlin, Md 4/21/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-23-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Fruitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury Md.		24a. REC'D BY REGISTRAR APR 28 '61 DATE APR 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

ASSAYED AT THE UNIVERSITY OF CALIFORNIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04979

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
c. LENGTH OF STAY IN TB <u>50 yrs.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Henry Lewis</u>		4. DATE OF DEATH Month Day Year <u>April 30 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1886</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Bill. Lewis</u> Address <u>Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>141.9</u> DUE TO <u>Acute Myocarditis?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Tongue?</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 1</u> , 19 <u>61</u> , to <u>Apr. 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Apr. 29</u> , 19 <u>61</u> , and that death occurred at <u>3:27</u> P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.		DATE SIGNED <u>Apr 30 1961</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT MD BERLIN MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 30, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hamblin</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleysville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

Form D-2, 1944

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Jan 15 1945</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. DISEASE OR INJURY <i>Coronary Artery Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>J. H. Jones</i>		12. SIGNATURE OF REGISTRAR <i>M. A. Smith</i>	
13. SIGNATURE OF WITNESSES <i>W. B. Brown, C. D. Green</i>		14. SIGNATURE OF DECEASED <i>John J. Smith</i>	
15. SIGNATURE OF FUNERAL HOME <i>John's Funeral Home</i>		16. SIGNATURE OF BURIAL PLACE <i>St. Mary's Cemetery</i>	
17. SIGNATURE OF COUNTY CLERK <i>John Doe</i>		18. SIGNATURE OF STATE CLERK <i>John Doe</i>	
19. SIGNATURE OF MAYOR <i>John Doe</i>		20. SIGNATURE OF COMMISSIONER <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John J. Smith</i>		22. SIGNATURE OF DECEASED <i>John J. Smith</i>	
23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF DECEASED <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF DECEASED <i>John J. Smith</i>	
27. SIGNATURE OF DECEASED <i>John J. Smith</i>		28. SIGNATURE OF DECEASED <i>John J. Smith</i>	
29. SIGNATURE OF DECEASED <i>John J. Smith</i>		30. SIGNATURE OF DECEASED <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF DECEASED <i>John J. Smith</i>	
33. SIGNATURE OF DECEASED <i>John J. Smith</i>		34. SIGNATURE OF DECEASED <i>John J. Smith</i>	
35. SIGNATURE OF DECEASED <i>John J. Smith</i>		36. SIGNATURE OF DECEASED <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF DECEASED <i>John J. Smith</i>	
39. SIGNATURE OF DECEASED <i>John J. Smith</i>		40. SIGNATURE OF DECEASED <i>John J. Smith</i>	
41. SIGNATURE OF DECEASED <i>John J. Smith</i>		42. SIGNATURE OF DECEASED <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF DECEASED <i>John J. Smith</i>	
45. SIGNATURE OF DECEASED <i>John J. Smith</i>		46. SIGNATURE OF DECEASED <i>John J. Smith</i>	
47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF DECEASED <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF DECEASED <i>John J. Smith</i>	
51. SIGNATURE OF DECEASED <i>John J. Smith</i>		52. SIGNATURE OF DECEASED <i>John J. Smith</i>	
53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF DECEASED <i>John J. Smith</i>	
57. SIGNATURE OF DECEASED <i>John J. Smith</i>		58. SIGNATURE OF DECEASED <i>John J. Smith</i>	
59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF DECEASED <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF DECEASED <i>John J. Smith</i>	
63. SIGNATURE OF DECEASED <i>John J. Smith</i>		64. SIGNATURE OF DECEASED <i>John J. Smith</i>	
65. SIGNATURE OF DECEASED <i>John J. Smith</i>		66. SIGNATURE OF DECEASED <i>John J. Smith</i>	
67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF DECEASED <i>John J. Smith</i>	
69. SIGNATURE OF DECEASED <i>John J. Smith</i>		70. SIGNATURE OF DECEASED <i>John J. Smith</i>	
71. SIGNATURE OF DECEASED <i>John J. Smith</i>		72. SIGNATURE OF DECEASED <i>John J. Smith</i>	
73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF DECEASED <i>John J. Smith</i>	
75. SIGNATURE OF DECEASED <i>John J. Smith</i>		76. SIGNATURE OF DECEASED <i>John J. Smith</i>	
77. SIGNATURE OF DECEASED <i>John J. Smith</i>		78. SIGNATURE OF DECEASED <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF DECEASED <i>John J. Smith</i>	
81. SIGNATURE OF DECEASED <i>John J. Smith</i>		82. SIGNATURE OF DECEASED <i>John J. Smith</i>	
83. SIGNATURE OF DECEASED <i>John J. Smith</i>		84. SIGNATURE OF DECEASED <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF DECEASED <i>John J. Smith</i>	
87. SIGNATURE OF DECEASED <i>John J. Smith</i>		88. SIGNATURE OF DECEASED <i>John J. Smith</i>	
89. SIGNATURE OF DECEASED <i>John J. Smith</i>		90. SIGNATURE OF DECEASED <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF DECEASED <i>John J. Smith</i>	
93. SIGNATURE OF DECEASED <i>John J. Smith</i>		94. SIGNATURE OF DECEASED <i>John J. Smith</i>	
95. SIGNATURE OF DECEASED <i>John J. Smith</i>		96. SIGNATURE OF DECEASED <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF DECEASED <i>John J. Smith</i>	
99. SIGNATURE OF DECEASED <i>John J. Smith</i>		100. SIGNATURE OF DECEASED <i>John J. Smith</i>	

1

See Official Book of the Registrar, Vol. 1, p. 10, for instructions regarding the use of this form.

NO ANSWERS BEING

10

4992

CERTIFICATE OF DEATH

04980

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST OCEAN City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST OCEAN City			
c. LENGTH OF STAY IN 1b 1 mos.				d. STREET ADDRESS 1 Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clara A. Massey				4. DATE OF DEATH 4 18 1961			
5. SEX Fm		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-13-1875	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR — Months — Days — Hours — Min.		IF UNDER 24 HRS. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife				10b. KIND OF BUSINESS OR INDUSTRY Maternity		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Charles E. Davis				14. MOTHER'S MAIDEN NAME Carolyn Smack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Mrs. Ida Purcell, Berlin, Md, Rt #3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) "							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/2 , 19 61 , to 4/18 , 19 61 , that I last saw the deceased alive on 4/18 , 19 61 , and that death occurred at 11 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 4/20/61							
ACTUAL SIGNATURE Ivory U. Sully, Jr., MD.				PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD Berlin, Md. 4/20/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-22-61			
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM-				22d. LOCATION (City, town, or county) (State) BERLIN, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md.				24a. REC'D BY REGISTRAR APR 28 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid			

(M)

(1)

STATE OF NEW YORK

CERTIFICATE OF DEATH

1900

1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

Dec 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4993
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04981

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards 22X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home		d. STREET ADDRESS Main St	
3. NAME OF DECEASED (Type or print) First CLEORA Middle LEE Last PHILLIPS		4. DATE OF DEATH Month APRIL Day 23rd Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wico. County-Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Brumbley		14. MOTHER'S MAIDEN NAME Jane Ennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) INFORMANT Mrs. Vivian P. Ball (Grand-Daughter) Willards, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs - 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute upper respiratory disease (common cold)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1958 19 to date of death 19, that (I) (we) last saw the deceased alive on 4-23 19 61 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank R. Lewis		22b. DATE SIGNED Apr. 24 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Line Church Cem. - Near Whitaker R.D. #Pittsville		23d. LOCATION (City, town, or county) (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE APR 26 '61	
25b. REGISTRAR'S SIGNATURE Salisbury Maryland		25c. REGISTRAR'S SIGNATURE Arthur S. Kinas	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4994

04982

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 411 Market Street				d. STREET ADDRESS 411 Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SADIE Middle O. Last POWELL				4. DATE OF DEATH Month April Day 27 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1873	
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sewell D. Powell				14. MOTHER'S MAIDEN NAME Alice Ball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 411 Market St. Mrs Ruth Powell, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 433-1 IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Pulmonary Oedema DUE TO (c) Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Minutes 2 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 24, 1961 to Apr. 27, 1961 , that (I) (we) last saw the deceased alive on Apr. 27, 1961 , and that death occurred at 245 AM , from the causes and on the date stated above.							
22a. SIGNATURE Charles W. Trader				22b. DATE Apr. 28, 1961		22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.	
22d. ADDRESS 302 Market St., Pocomoke City, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-29-61		23c. NAME OF CEMETERY Presbyterian		23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				25a. REC'D BY REGISTRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1924

1

Decedent's Name: Joseph G. Powell
Age: 60 Years
Sex: Male
Race: White
Marital Status: Married
Usual Residence: 111 Market Street, Baltimore City, Md.
Cause of Death: Heart Disease
Date of Death: July 23, 1924
Place of Death: Home
Physician: None
Burial Place: None
Signature of Physician: None
Signature of Registrar: None
Signature of Coroner: None

[Faint, illegible text, likely bleed-through from the reverse side of the document]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4995
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04983

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>75 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Jay) George R. Purnell</u>				4. DATE OF DEATH <u>April 11 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25-1885</u>	
9. AGE (In years last birthday) <u>75 4/16</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill</u>			
13. FATHER'S NAME <u>Wesley Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Annice Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or last town) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-12-0033</u>		17. INFORMANT <u>Mrs. Rosalia Purnell</u>		Address <u>202 Pettit Street Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 hr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> 19 <u>61</u> , to <u>4-11</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4-11</u> 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David Rafat</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>				22d. ADDRESS <u>Snow Hill, md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Relay & Dumas</u>				ADDRESS <u>Snow Hill, md</u>		25a. REC'D BY REGISTRAR DATE <u>APR 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

(M)

(I)

(M)

(I)

RECEIVED
JAN 11 1911

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04984

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>501 Main St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Charles Williams Richardson</i>		4. DATE OF DEATH <i>April 6 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26 '93</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tool clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clerical</i>	
11. BIRTHPLACE (State or foreign country) <i>Berlin Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Richardson</i>		14. MOTHER'S MAIDEN NAME <i>Sadie Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>224-05-3578</i>	
17. INFORMANT <i>MRS. E. W. RICHARDSON</i>		Address <i>BERLIN MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>976X Suicide by firearm</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Colts</i> (c) <i>Interval between onset and death 1 year</i> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 Bad nerves for over 3 years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self-inflicted wound, gunshot above heart downward through heart to edge of shoulder on the lower back.</i>	
20c. TIME OF INJURY Month, Day, Year <i>4-6-61</i> Hour <i>1:45</i> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Berlin</i> (County) <i>Worcester</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>N. E. Sartorius Jr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius Sr M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>4/6/61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/8/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>		22d. LOCATION (City, town, or county) <i>BERLIN</i> (State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna H. Burboze</i>		ADDRESS <i>Berlin Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE APR 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1900</i>	
PLACE OF BIRTH <i>Johns Hopkins</i>		OCCUPATION <i>Physician</i>		EDUCATION <i>Harvard</i>		MARRIAGE <i>Married</i>	
DATE OF DEATH <i>Jan 20 1945</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		SYMPTOMS <i>Chest pain</i>		TREATMENT <i>None</i>	
SIGNATURE OF EXAMINER <i>Dr. J. Doe</i>		DATE <i>Jan 21 1945</i>		PLACE <i>Baltimore</i>		OFFICE <i>City</i>	

M

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE, MARYLAND, FOR RECORD IN THE COUNTY CLERK'S OFFICE.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4997

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>75 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DELLA</u> Middle <u>RICHARDSON</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11, 1885</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WHALEYVILLE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>WILLIAM JAMES JONES</u>				14. MOTHER'S MAIDEN NAME <u>ALEXINIA SARVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>MR. THOMAS ZULLEN</u> Address <u>BERLIN MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Essential hypertension</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/4</u> , 19 <u>61</u> , to <u>4/10</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>61</u> , and that death occurred at <u>10:35 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sullivan, Jr.</u> M.D.				DATE SIGNED <u>4/11/61</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sullivan, Jr.</u>				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN (R.F.D.) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbyc</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knepp</u>	

M

I

0

1

MAY 11 1882

ARGENTIA JARVIS

MR THOMAS LUTCH, GREEN IS.

4/4

Green Is.

July 1st, 1882

Green Is.

Green Is.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

4998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04986

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke (Rural) all life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home				e. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ester Middle Schofield Last				4. DATE OF DEATH		Month Day Year Apr. 18 19 61	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1885 76 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gus Bevins		14. MOTHER'S MAIDEN NAME Ellen ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Bernie Schofield 631 1/2 Main St. Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO (b) Conflagration (c) Short Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Worcester (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-23-61		22c. NAME OF CEMETERY OR CREMATORY Trinity Chapel	
22d. LOCATION (City, town, or county) Pocomoke, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - Pocomoke, Va.				24a. REC'D BY REGISTRAR DATE APR 24 '61		24b. REGISTRAR'S SIGNATURE	

I

23

2

AP

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 14 Film G285 4/17/61 mh											
04987											
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Worcester						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Showell					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Showell						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XXX					d. STREET ADDRESS XXX						
3. NAME OF DECEASED (Type or print) ANNIE ELIZABETH STULLER					4. DATE OF DEATH April 9 1961						
5. SEX Female					6. COLOR OR RACE White						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Feb. 28, 1873						
9. AGE (In years last birthday) 88 yrs.					10. IF UNDER 1 YEAR Months Days						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home						
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Thomas Nelson					14. MOTHER'S MAIDEN NAME Susan Alice Fleagle						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX					16. SOCIAL SECURITY NO. XX						
17. INFORMANT J. H. Stuller Showell, Md.					Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 4444X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-15 61 to 4-7 61, that (I) (we) last saw the deceased alive on 4-5 61, and that death occurred at 7A.M. from the causes and on the date stated above.										22a. SIGNATURE Clifford E. Schott	
22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT										22b. DATE SIGNED	
22d. ADDRESS BERLIN, MD.										22e. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 4/12/61	
23c. NAME OF CEMETERY OR CREMATORY Church of God										23d. LOCATION (City, town or county) (State) Uniontown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Md.										25a. REC'D BY REGISTRAR DATE APR 12 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus										25c. DATE	

1

M

X

I

0

1

00

100

100

100

100

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04988

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop c. LENGTH OF STAY IN 1b 10-yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop d. STREET ADDRESS Rt. #1 Box 46 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mammie Middle N. Last STURGIS		4. DATE OF DEATH Month April Day 16th Year 19 61	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-95
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66	11. IF UNDER 24 HRS. Days 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Turlington	
14. MOTHER'S MAIDEN NAME Agnes Moore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. --		17. INFORMANT Fred Sturgis Address Bishop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/19 , 19 54 , to 4/9 , 19 61 , that I last saw the deceased alive on 4/9 , 19 61 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 4-16-61			
ACTUAL SIGNATURE Ivory U. Sully PHYSICIAN'S NAME (Type) Ivory U. SULLY		M.D. Berlin, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-16-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	22d. LOCATION (City, town, or county) (State) Exmore, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Thomas Funeral Home ADDRESS Accomac, Va.		24a. REC'D BY REGISTRAR APR 19 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR A FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: (1) Name of deceased, (2) Date of death, (3) Place of death, (4) Usual residence, (5) Cause of death, (6) Date of birth, (7) Sex, (8) Color or race, (9) Marital status, (10) Usual occupation, (11) Birthplace, (12) Citizen of what country, (13) Father's name, (14) Mother's maiden name, (15) Was deceased ever in U. S. Armed Forces? (16) Social Security No., (17) Informant, (18) Cause of death, (19) Was autopsy performed? (20) Accident was underlying or contributing cause of death, (21) Time of injury, (22) Injury occurred, (23) Place of injury, (24) City or town, (25) County, (26) State, (27) I certify that (I) (this hospital) attended the deceased from, (28) 4/2 1961 to, (29) 4/5 1961, that (I) (we) last saw the deceased alive on, (30) 4/5 1961 and that death occurred at, (31) 6 PM, from the causes and on the date stated above. (32) Signature of David Rafat, (33) Physician's name (Type) DAVID RAFAT, (34) Address 22d. ADDRESS Suder Hill, Md., (35) Burial, cremation, removal (Specify) Burial, (36) Date thereof 4-8-61, (37) Name of cemetery Wesley Methodist, (38) Location (City, town, or county) Stockton, Maryland, (39) Funeral director's signature Robert H. Watson, (40) Address Pocomoke City, Md., (41) Rec'd by registrar APR 10 '61, (42) Registrar's signature Arthur L. Kraus.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6258

04989

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holland's Nursing Home				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle ANNE Last TAYLOR				4. DATE OF DEATH Month April Day 5 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1867	
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Sallie Elizabeth Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs J. Warren Smith, Stockton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO (b) Arteriosclerosis Generalized DUE TO (c) yes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/2 1961 to 4/5 1961 , that (I) (we) last saw the deceased alive on 4/5 1961 and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE David Rafat				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT				22d. ADDRESS Suder Hill, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-8-61		23c. NAME OF CEMETERY Wesley Methodist	
23d. LOCATION (City, town, or county) Stockton, Maryland				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				25a. REC'D BY REGISTRAR APR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
25c. ADDRESS Pocomoke City, Md.				25d. DATE			

M

I

1

34

(M)

Worcester

Hotel - Worcester

Hotel's running hours

Worcester

Worcester

John Taylor

No.

None

Worcester, Mass. 1873

Worcester, Mass.

Worcester

Worcester

Worcester

Worcester, Mass.

Worcester

Worcester

Worcester

Worcester

Worcester, Mass.